

What is Stigma- and Discrimination-Informed Practice?

A resource for service providers and caregivers

Stigma- and Discrimination-Informed Practice (SDIP) is an everyday caregiving skill practiced by recognizing that stigma leads to discrimination and that both are present-tense harms shaping how people experience care environments. Trauma-Informed Practice alone does not consider how judgment, conditional access, and systemic power operate in real time. SDIP closes this gap. It centres dignity in care and defines safety as the freedom to disclose needs without fear of punishment, loss of access, or humiliation. By addressing stigma directly, SDIP ensures trauma-informed care is not only compassionate in intent but trustworthy in experience.

How to Cite this Document

Fisk, S. (2026). What is Stigma- and Discrimination-Informed Practice? Ottawa, ON: CAPSA.
<https://capsa.ca/resources/>

Why SDIP is Essential

Trauma-Informed Practice (TIP) gave health and social care a vital foundation. It recognizes that people's past experiences of trauma shape how they approach and feel when receiving services. This understanding emphasizes safety, trust, and collaboration.

Yet Trauma-Informed Practice does not go far enough because it rarely names how stigma, discrimination, and systemic power continue to shape harm while people are actively seeking care. For many, especially those seeking support for their Substance Use Health, the most significant harm they encounter is not only historical. It happens in the present moment.

Stigma and discrimination are present-tense traumas. They occur in real time when people seek help and are met with judgment, dismissal, suspicion, or conditional care. CAPSA's national research consistently identifies stigma as a leading barrier to care, while system-level work shows it is structural as well as interpersonal and intersects with other forms of discrimination.

Equally important, CAPSA's community-led and practice-based evidence shows that people want caregivers to understand how stigma has affected them and continues to affect them today. Without the recognition of how stigma, leading to discrimination, has played out, even when trauma-informed care is practiced, stigma can inadvertently retraumatize, reproducing the very harm TIP aims to prevent.

SDIP closes this gap by exposing how safety is often made conditional in caregiving environments. In many systems, people experience safety only when they withhold information, comply with expectations, or manage how much of their reality they reveal. SDIP exists to ensure that safety is not something that can be granted, reduced, or withdrawn based on behaviour or comfort. When safety is conditional, dignity is already compromised, because people learn that their worth is measured by how they perform rather than by who they are.

Dignity as the Condition for Care

The opposite of stigma is dignity. It is both the starting point and the standard for care.

In SDIP, dignity in care means that a person's worth is never assessed, negotiated, earned, or withdrawn within the caregiving relationship.

It is not based on behaviour, disclosure, stability, or agreement with a care plan. It does not disappear when a person is struggling, returning to care, changing goals, or declining support. Dignity is not a reward for progress, and it is not lost through recurrence.

Dignity in care is communicated through actions, not statements. People experience dignity when systems do not punish honesty, when disclosure does not trigger loss of access, and when support remains steady even as health fluctuates.

If, when seeking care, a person must protect themselves from the system or from those providing services in order to receive help, dignity is not present.

What SDIP Means by Safety

In SDIP, safety is defined by the quality of the caregiving environment, including how people experience the caregiving relationship itself.

Safety exists when caregiving spaces, systems, and relationships consistently signal that a person will not be punished, excluded, or diminished for being honest about their health, and that people will not think less of them because of their struggles or changing health needs. It is created through routines, policies, documentation practices, language, and relational responses that protect dignity in moments of vulnerability.

People experience safety when disclosure does not trigger surveillance, suspicion, withdrawal of support, increased monitoring, or loss of access. They know they can speak openly because the environment and the people in it have shown, over time, that honesty is met with presence and understanding.

If people feel they must manage information, hide parts of themselves, or wait until crisis to seek help, the caregiving environment is not safe, regardless of how it is described.

The Weight of Stigma in Care

Stigma is not abstract. It appears in everyday interactions and in the rules that govern access to care. People are judged or labelled as non-compliant rather than understood in context, which shifts care away from support and toward monitoring, narrows access to services, discourages disclosure, and teaches people that their needs will be interpreted as problems instead of health realities.

Anticipated discrimination keeps many from seeking help at all. Language that blames or pathologizes creates unsafe environments where disclosure feels risky.

Institutional practices such as punishing recurrence, imposing unnecessary barriers, and enforcing rigid exclusion criteria deepen mistrust. These practices reinforce power imbalances and erode dignity by teaching people that access to care depends on how safely they perform rather than on their health needs.

Because substance use stigma rarely occurs in isolation, intersectional harms compound its effects, leaving services inaccessible and unsafe, even when they are called trauma informed.

Shifting the Focus of Care

When someone seeks care, they are entering systems that often do not preserve their dignity. It is not just that stigma is “out there.” Many systems are structured in ways that strip dignity through assessment processes, documentation, surveillance, exclusion criteria, punitive policies, or even physical design. The messaging within some spaces often sends a similar signal, reminding people that care is conditional or that they are being watched rather than welcomed. These built-in features can be harmful by nature.

Caregivers are not neutral actors within neutral systems. They are part of a structure that has the potential to harm unless they are actively working to interrupt those harms. This is not about individual failure; it is about recognizing that most systems were not built with dignity at the centre.

SDIP re-centres care on the person. It asks providers to actively examine everyday routines, documentation practices, language, and decision-making processes to identify where dignity is being eroded, and to respond by practicing presence, humility, and accountability, naming harm when it occurs, and rebuilding relationships grounded in mutual respect and shared humanity.

How SDIP Strengthens and Shows Up in Practice

Stigma- and Discrimination-Informed Practice (SDIP) does not replace Trauma-Informed Practice (TIP); it brings it to life and makes it credible. By directly addressing stigma, discrimination, and systemic power imbalances, SDIP ensures that trauma-informed care is not just safe in theory but effective in practice.

Without SDIP, trauma-informed approaches risk becoming language-deep but practice-shallow, adopting the words of compassion without disrupting the structures that perpetuate harm. SDIP asks caregivers, teams, and organizations to learn directly from those seeking care to understand how stigma and discrimination shape access, trust, and safety, and to adapt in real time.

In this way, SDIP transforms trauma-informed philosophy into daily practice that prevents re-traumatization, strengthens relationships, and builds genuine confidence in care.

By explicitly addressing stigma and structural imbalances, SDIP:

- **Centres dignity.** Dignity is the foundation for all safety, trust, and care. It cannot depend on behaviour, compliance, or provider comfort.
- **Reframes recurrence as a health reality.** Returning to care is not failure; it signals trust and continuity of relationship. “You are welcome back here, now and always.”
- **Challenges systemic harms.** Identify and disrupt the structures, policies, and language that reinforce bias or strip dignity.
- **Builds cultural humility.** Treat reflection, feedback, and learning as ongoing processes, not one-time trainings.
- **Grounds care in community-led evidence.** Lived and living experience are essential sources of expertise that keep systems accountable and person-centred.
- **Strengthens capacity across systems.** Invests in supervision, education, and skill building so that dignity-centred care is sustained in both practice and policy.

When SDIP is fully integrated, care becomes what it promises to be: safe, responsive, and worthy of people’s confidence. It ensures that trauma-informed practice is not just compassionate in intent but compassionate in outcome.

Integrating SDIP into Everyday Caregiving

Putting SDIP into practice is not about adopting a checklist. It is about reshaping how care is offered so that dignity is never conditional.

Caregivers can begin integrating SDIP by:

- **Using dignity-affirming language:** Choose words that signal respect, safety, and worth. Avoid moral framing or labels; speak in person-first, present-focused language.
- **Welcoming a return to care after recurrence:** Approach recurrence with openness and kindness. Meet people with support, not suspicion or disappointment.
- **Practicing presence: Stay connected through difficulty.** Offer care that is consistent and grounded in empathy, not performance.
- **Recognizing and sharing power:** People already hold knowledge and agency. Co-create plans that honour that expertise.
- **Advocating within systems:** Speak up when policies or norms compromise dignity. Advocacy is part of compassionate care.
- **Embedding humility and accountability:** Make self-reflection and team feedback routine, not optional.
- **Sustaining relational skill:** Develop mentorship and capacity building that help teams stay grounded in compassion over time.

When care is stigma- and discrimination-informed, trauma-informed principles move from theory to lived experience and people can feel the difference.

How Will I Know if SDIP Is Embedded in My Caregiving?

You'll notice SDIP becoming part of your caregiving not by what you intend, but through how people experience you. These signals often appear quietly in the relationship and reflect a health-focused understanding of substance use on a spectrum, not as behaviour to judge or correct.

Caregivers often recognize SDIP is taking root when:

- 1. People return to care without hesitation or fear of being met with frustration.** Their return reflects trust, not worry about disappointing you. Changes in support needs are understood as part of their health, not as setbacks.
- 2. New or emerging health needs, including recurrence, are met with compassion rather than disappointment.** People sense that their shifting Substance Use Health will not trigger frustration, withdrawal, or conditional care. Recurrence is treated as a health reality, not a judgement of motivation or stability.
- 3. The people you support feel free to direct their own health choices without judgment.** They exercise agency openly. Their decisions are treated as health decisions, not moral ones.

4. Your presence remains consistent in moments where stigma would normally appear. Recurrence, changes in a person's relationship with substances, or how a person shows up in a moment of need do not alter the quality of the relationship or the dignity you offer.

5. People begin sharing more, asking for what they need, and guiding the pace of their care. Their confidence grows because they experience dignity, predictability, and unconditional belonging in the relationship.

Commitment to Shared Humanity

An SDIP approach ensures that services are measured not only by what is offered but by how care is experienced. When stigma- and discrimination-informed principles guide care, they remind us to ask:

- Did we name and interrupt systemic harms?
- Did our language affirm dignity and shared humanity?
- Did we recognize that stigma compounds trauma and inequity?
- Was care offered as a right, not something to be earned?
- Did we centre reflection, humility, and accountability in our practice?

This commitment transforms care from a set of interventions into a shared practice of compassionate accountability, one where people feel safe, respected, and connected in our shared humanity, free from stigma in every interaction.

Stigma is an embedded harm that lives within systems, language, and relationships. It shapes how people are seen, spoken to, and treated, often before care even begins.

SDIP ensures care does not repeat those harms. It names and challenges discrimination wherever it appears, restoring respect, accountability, and connection in every interaction.

When providers lead with dignity and understand how discrimination has shaped people's experiences of care, they build environments where people feel valued, supported, and safe to return, where compassion is practiced, not just promised.

References:

- CAPSA. (2022). Code of conduct for engaging with people with lived and living experience. Ottawa, ON: Author.
- CAPSA. (2024). What do we mean by substance use health? Ottawa, ON: CAPSA.
- CAPSA & Canadian Centre on Substance Use and Addiction. (2019). Overcoming stigma through language: A primer. Ottawa, ON: CAPSA & CCSA.
- CAPSA & Royal Ottawa Hospital. (2024). Summary report: Intersectional stigma and anti-racism health equity summit. Ottawa, ON: CAPSA & Royal Ottawa Hospital.
- Epp, T., Fisk, S., Peters, B. (2024). Overdose? Let's Call it What it Is: A Substance Use Medical Emergency. Ottawa, ON: CAPSA.
- Fisk, S. (2023). The co-leadership process and meaningful engagement. Ottawa, ON: Author.
- Fisk, S. (in press). Creating a Culture of Care: Compassionate Leadership Certification [Course materials: Compassionate Leadership Certification Micro-Credentials 1-6]. Ottawa, ON: CAPSA.
- Fisk, S., & Hyland, A. (2025). "Actually, it's more clinical than just a relapse." Understanding a return to the use of substances as a recurrence of symptoms leads to compassion. Ottawa, ON: CAPSA.
- Fisk, S., & Peters, B. (2023). Compassionate care: How to stay well while helping others. Ottawa, ON: CAPSA.
- Mahon, D. (2025). A systematic review of trauma-informed care implementation in substance use settings. *Community Mental Health Journal*, 61(4), 734–753. <https://doi.org/10.1007/s10597-024-01395-z>
- Mental Health Commission of Canada, Canadian Centre on Substance Use and Addiction, & CAPSA. (2023). Experience and expertise of people with lived and living experience on the integration of mental health and substance use health services in Canada: Summary report. Ottawa, ON: MHCC, CCSA, & CAPSA.
- Peters, B., De Moor, C., Garner, G., Williamson, L., & Epp, T. (2025). Recommendations to improve access to substance use health information and supports in Canada. Ottawa, ON: CAPSA & CCSA.
- Peters, B., Garner, G., & Williamson, L. (2023). The starting place: Understanding systemic stigma barriers to knowledge about substance use health and associated services in Canada. Ottawa, ON: CAPSA & CCSA.
- Rogers, C. R. (1961). *On becoming a person: A therapist's view of psychotherapy*. Boston, MA: Houghton Mifflin.
- Standards Council of Canada, Mental Health & Substance Use Health Standardization Collaborative. (2024). *Mental health and substance use health standardization roadmap*. Ottawa, ON: Standards Council of Canada.
- Tam, T. (2019). *Addressing stigma: Towards a more inclusive health system*. Public Health Agency of Canada.